and is amenable to cognitive–analytic therapy. This may indeed be so. Unfortunately, from my perspective, it does not solve the problem, if only because the psychoanalytic concept of borderline personality only embraces a small part of personality disorder as a whole. Dr Ryle also asserts that 'the need is . . . for an understanding of persons' and has no sympathy with my (and, I presume, Dr Bennett's) interest in 'underlying cerebral mechanisms'. Many psychotherapists would agree with him. But I still have to insist that we must agree what is implied by the term mental illness before we can decide whether personality disorders are mental illnesses or not, and that the forensic issues involved mean that this is not a trivial issue.

Professor Pilgrim asks, perhaps with tongue in cheek, whether Scadding's definition of disease (not mental disorder) implies that being male or poor are diseases. The answer in both cases is, of course, no. Scadding's definition refers explicitly to variation 'from the norm for the species', so the reference group for a putative male disease would be the life expectancy of other males. Likewise, poverty is a handicap imposed by the environment which may increase the risk of several diseases, and thereby reduce life expectancy, but is not itself a disease. For similar reasons, living in a zoo rather than a natural habitat is a disadvantageous environment for many wild animals, not a disease of wild animals, despite the implications for longevity. More importantly, Professor Pilgrim refers to the 'logical superiority of a dimensional over a categorical approach' to the classification of personality disorders and chides psychiatrists for what he regards as their inappropriate attachment to categories. I would argue that the relative merits of categorical and dimensional classifications is an empirical issue rather than a matter of logic, and that their relative advantages and disadvantages may vary with the purpose for which the classification is to be used. In fact, it is explicitly recognised in ICD–10 that personality disorders 'represent either extreme or significant deviations from the way the average individual . . . perceives, thinks, feels, and particularly relates to others'. It is also on the cards that in DSM–V the American Psychiatric Association will replace its present categorical classification of personality disorders with a set of dimensions.

Lewis, A. (1953) Health as a social concept. *British Journal of Sociology*, **4**, 109–124.

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Patient adherence with antidepressant treatment

Reading the article by Pampallona *et al* (2002) on patient adherence in the treatment of depression, I sought in vain for any overt indication that mental health service users themselves were routinely being asked for their views, either by practitioners or by researchers. 'Patient education' and 'education of the patient's family' may well be interventions worthy of study, but methodologies used to look at this problem appear to fail to take account of what mental health professionals can learn from patients, families and carers.

A recent survey of over 2600 service users and carers, undertaken by the National Schizophrenia Fellowship, the Manic Depression Fellowship and Mind (Hogman & Sandamas, 2001) found that 27% had not had their medicine discussed with them, 46% had not received any written information about the possible side-effects of medicine, and a startling 62% had never been offered a choice of medicine. The survey concluded that, 'Positive outcomes are increased if people are informed about their choices, allowed to choose and given their choice'. This message seems slowly to be seeping into the consciousness of our political masters, with Hazel Blears, Parliamentary Under Secretary of State for Health, actively promoting increased informed choice for patients, including treating patients as partners in care, and giving them the confidence to take control of their own treatment. When the medical profession as a whole can embrace this in respect of patients with a mental illness then, unlike Pampallona and his colleagues, we may be some way nearer to finding out what interventions work successfully.

Blears, H. (2002) *Further Steps to Patient-Centred NHS*. Press release, Department of Health, 29 January 2002. http://tap.ccta.gov.uk/doh/intpress.nsf/page/2002-0046?OpenDocument

Hogman, G. & Sandamas, G. (2001) *A Question of Choice*. London: National Schizophrenia Fellowship.

Pampallona, S., Bollini, P., Tibaldi, G., *et al* (2002) Patient adherence in the treatment of depression. *British Journal of Psychiatry*, **180**, 104–109.

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In an interesting article, Pampallona *et al* (2002) reviewed the literature concerning patient adherence in the treatment of depression. The outcome of most studies revealed that interventions to improve adherence tend to be successful in most cases, although it is not completely clear which interventions may be the most helpful.

In our view, the most important goal in trying to enhance adherence is to improve treatment outcome. Pampallona *et al* stated that 'the important relationship between adherence and outcome of treatment has been evaluated only in one study'.

When we reviewed the articles that Pampallona *et al* included in their article, however, we identified at least four studies that addressed the relationship between adherence and treatment outcome.

Katon *et al* (1995, 1996) demonstrated that multifaceted interventions improved adherence to antidepressant regimens in patients with major and with minor depression. The interventions resulted in more favourable outcomes in patients with major, but not minor, depression. In a more recent study of the same group (Katon *et al*, 1999) patients in the intervention group also had significantly better adherence to antidepressive medication and showed a significantly greater decrease in severity of depressive symptoms over time and were more likely to have fully recovered during follow-up at 3 and 6 months. Peveler *et al* (1999) found that counselling about drug treatment significantly improved adherence. Clinical benefit, however, was seen only in patients with major depressive disorder receiving doses $\geqslant 75$ mg of a tricyclic antidepressant.

These findings provide evidence that interventions can enhance adherence and can increase the response rate in patients with major depression who are treated with an adequate dosage of an antidepressant agent. With respect to minor depression results are less convincing.

Katon, W., Von Korff, M., Lin, E., *et al* (1995) Collaborative management to achieve treatment guidelines. Impact on depression in primary care. *JAMA*, **273**, 1026–1031.

—, Robinson, P., Von Korff, M., *et al* (1996) A multifaceted intervention to improve treatment of depression in primary care. *Archives of General Psychiatry*, **53**, 924–932.

—, Von Korff, M., Lin, E., *et al* (1999) Stepped collaborative care for primary care patients with resistant symptoms of depression. *Archives of General Psychiatry*, **56**, 1109–1115.

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